

**Spring Valley Clinic**  
**5323 Spring Valley Rd, Ste 100**  
**Dallas, TX 75254**

**CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE**

**Patient Information**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Email address: \_\_\_\_\_ Sex:  Male  Female

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation (job title): \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Which telephone number would you like us to use for appointment reminders? Home / Work / Cell

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**Insurance Information**

Who is responsible for this account? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Suscriber's name: \_\_\_\_\_

Suscriber's birth date: \_\_\_\_\_ SSN: \_\_\_\_\_

**Assignment of Benefits**

*I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ (name of insurance carrier) and assign directly to \_\_\_\_\_ (name of doctor) all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.*

Responsible Party Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Reason for Visit**

Describe what hurts, or your reason for this visit: \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Is it getting worse?  Yes  No

When did your symptoms start? \_\_\_\_\_ How did your symptoms begin? \_\_\_\_\_

How often do you experience symptoms? (Circle one) Constantly Frequently Occasionally Intermittently

What seems to make it better? \_\_\_\_\_

What seems to make it worse? \_\_\_\_\_

Does it bother your:  Sleep  Work  Daily activity  \_\_\_\_\_

Have you had acupuncture before?  Yes  No

Have you had Herbal Medicine before?  Yes  No

List other forms of treatment you have sought? \_\_\_\_\_

Do you have any additional health concerns or diagnosis? \_\_\_\_\_

List any accidents, surgeries, or hospitalizations (include dates): \_\_\_\_\_

List any Allergies that you are aware of: \_\_\_\_\_

List any medications (over the counter or prescription) or supplements you take:

RX / Supplement / Herb	Dose	Reason for taking	How long	Prescribed by	Last checkup
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**History of Treatment**

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Date last seen: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Email: \_\_\_\_\_

May we update them on your condition?  Yes  No

Have you seen another doctor for these symptoms? If yes, indicate name and type of medical provider: \_\_\_\_\_

\_\_\_\_\_

***Lifestyle History***

Do you exercise?  Yes  No Hours per week \_\_\_\_\_ What activity(s)? \_\_\_\_\_

\_\_\_\_\_

Are you dieting?  Yes  No Since: \_\_\_\_\_

Do you smoke?  Yes  No \_\_\_\_\_ packs per day. How long have you been smoking? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No \_\_\_\_\_ drinks per week.

For women: Are you pregnant or nursing?  Yes  No

If pregnant, How many weeks? \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

Do you currently use or have you used in the past:

Alcohol  Tobacco  Marijuana  other drugs

***Your Diet***

Appetite:  Low  Normal  High

Do you consume or crave any of the following:

Coffee  Artificial Sweetener  Salty Food  Soft Drinks  Sugar

Thirst for water: \_\_\_\_\_ # of glasses per day

Average Daily Menu:

Morning                      Snack                      Noon                      Snack                      Evening                      Snack

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Your Past Medical History

Check all of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history:

- |                                       |  |   |  |  |
|---------------------------------------|--|---|--|--|
| <input type="checkbox"/> HIV / AIDS   | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Seizures          | <input type="checkbox"/> Whooping Cough  |
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke            | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Allergies    | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Thyroid Disorders | _____                                    |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Major Trauma      | _____                                    |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Gout                | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Tuberculosis      | _____                                    |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Polio              | <input type="checkbox"/> Typhoid Fever     | _____                                    |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Ulcers            | _____                                    |
| <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever      | <input type="checkbox"/> Venereal Disease  | _____                                    |

### General Symptoms:

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> Poor appetite             | <input type="checkbox"/> Poor sleep            | <input type="checkbox"/> Bodily heaviness    | <input type="checkbox"/> Chills               | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy appetite            | <input type="checkbox"/> Heavy sleep           | <input type="checkbox"/> Cold hands or feet  | <input type="checkbox"/> Night sweats         | <input type="checkbox"/> Peculiar taste         |
| <input type="checkbox"/> Strongly like cold drinks | <input type="checkbox"/> Dream-disturbed sleep | <input type="checkbox"/> Poor circulation    | <input type="checkbox"/> Sweat easily         | <input type="checkbox"/> Other (specify)        |
| <input type="checkbox"/> Strongly like hot drinks  | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Muscle cramps        | _____   |
| <input type="checkbox"/> Recent weight loss/gain   | <input type="checkbox"/> Lack of strength      | <input type="checkbox"/> Fever               | <input type="checkbox"/> Vertigo or dizziness | _____   |

### Head, Eyes, Ears, Nose & Throat:

- |   |  |  |   |  |
|---|--|--|---|--|
| <input type="checkbox"/> Glasses        | <input type="checkbox"/> Night blindness | <input type="checkbox"/> Sores on lips/tongue  | <input type="checkbox"/> Swollen glands   | <input type="checkbox"/> Migraines       |
| <input type="checkbox"/> Eye strain     | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Lumps in throat  | <input type="checkbox"/> Concussions     |
| <input type="checkbox"/> Eye pain       | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Excessive saliva      | <input type="checkbox"/> Enlarges thyroid | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Red eyes       | <input type="checkbox"/> Teeth problems  | <input type="checkbox"/> Sinus problems        | <input type="checkbox"/> Nose bleeds      | _____                                    |
| <input type="checkbox"/> Itchy eyes     | <input type="checkbox"/> Grinding teeth  | <input type="checkbox"/> Excessive phlegm      | <input type="checkbox"/> Ringing in ears  | _____                                    |
| <input type="checkbox"/> Spots in eyes  | <input type="checkbox"/> TMJ             | color of phlegm: _____                         | <input type="checkbox"/> Poor hearing     | _____                                    |
| <input type="checkbox"/> Poor vision    | <input type="checkbox"/> Facial pain     | _____  | <input type="checkbox"/> Earaches         | _____                                    |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Gum problems    | <input type="checkbox"/> Recurrent sore throat | <input type="checkbox"/> Headaches        | _____                                    |

### Respiratory:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Difficulty breathing when lying down | <input type="checkbox"/> Asthma/wheezing | Color of phlegm? _____                  |
| <input type="checkbox"/> Shortness of breath                  | <input type="checkbox"/> Cough           | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Tight chest                          | Wet or Dry? _____                        | <input type="checkbox"/> Pneumonia      |
|   | Thick or thin? _____                     |   |

### Cardiovascular:

- |  |   |   |   |  |
|--|---|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Chest pain           | <input type="checkbox"/> Tachycardia        | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat |

### Musculoskeletal:

- |   |  |                                     |  |  |
|---|--|-------------------------------------|--|--|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Limited range of motion | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Muscle pain        | <input type="checkbox"/> Low back pain   | <input type="checkbox"/> Rib pain   | <input type="checkbox"/> Limited use             | _____                                    |

**Gastrointestinal:**

- |   |   |  |                                     |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Itchy anus      | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Burning anus    | Bowel movements:                    |
| <input type="checkbox"/> Acid regurgitation | <input type="checkbox"/> Laxative use     | <input type="checkbox"/> Rectal pain     | Frequency_____                      |
| <input type="checkbox"/> Gas                | <input type="checkbox"/> Black stools     | <input type="checkbox"/> Hemorrhoid      | Color_____                          |
| <input type="checkbox"/> Hiccup             | <input type="checkbox"/> Bloody stools    | <input type="checkbox"/> Anal fissures   | Texture/form_____                   |
| <input type="checkbox"/> Bloating           | <input type="checkbox"/> Mucous in stools | <input type="checkbox"/> Intestinal pain | Odor_____                           |

**Skin and Hair:**

- |                                      |                                    |                                    |  |
|--------------------------------------|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Dandruff  | <input type="checkbox"/> Change in hair/skin texture |
| <input type="checkbox"/> Hives       | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Itching   | <input type="checkbox"/> Fungal infections           |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Acne      | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Other (specify)_____        |

**Neuropsychological:**

- |                                   |                                      |  |   |
|-----------------------------------|--------------------------------------|--|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Considered/attempted suicide |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Depression  | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Seeing a therapist           |
| <input type="checkbox"/> Tics     | <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Abuse survivor  | <input type="checkbox"/> Other (specify)_____         |

**Genito-urinary:**

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Blood in urine       | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Impotence             |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Decreased libido | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination   | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate  | <input type="checkbox"/> Kidney stone     | <input type="checkbox"/> Nocturnal emission    |

**Gynecology:**

- |   |  |  |   |
|---|--|--|---|
| Age menses began_____                                       | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Vaginal sores | # of Pregnancies_____                         |
| Length of avg. cycle _____<br><small>Day 1 to day 1</small> | <input type="checkbox"/> Painful periods   | <input type="checkbox"/> Vaginal odor  | # of live births _____                        |
| Duration of flow_____                                       | <input type="checkbox"/> PMS               | <input type="checkbox"/> Clots         | <input type="checkbox"/> Premature births (s) |
|   | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Breast lumps  | Age at menopause_____                         |

**Family Health History**

Are any of the following diseases in your family:

- |                                    |                                     |  |  |                                 |
|------------------------------------|-------------------------------------|--|--|---------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures            |                                 |

Please list all major diseases (such as Bone/Joint Diseases, Heart Problems, Stroke, etc.) in your family and the family member's relation to you

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## Symptom Checklist

For the conditions below please indicate if you have had the condition in the past or if you presently have the condition.

Past	Present	Condition	Past	Present	Condition	Past	Present	Condition
		<b><u>Musculoskeletal</u></b>			<b><u>Cardiovascular</u></b>			<b><u>Genitourinary</u></b>
<input type="radio"/>	<input type="radio"/>	Neck Pain	<input type="radio"/>	<input type="radio"/>	Angina/Chest Pain	<input type="radio"/>	<input type="radio"/>	Bladder Infection
<input type="radio"/>	<input type="radio"/>	Upper/Mid Back Pain	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>	Frequent Urination
<input type="radio"/>	<input type="radio"/>	Low Back Pain	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>	Painful Urination
<input type="radio"/>	<input type="radio"/>	Shoulder Pain	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>	Kidney Stones
<input type="radio"/>	<input type="radio"/>	Elbow/Upper Arm Pain	<input type="radio"/>	<input type="radio"/>	Stroke	<input type="radio"/>	<input type="radio"/>	Prostate Problems
<input type="radio"/>	<input type="radio"/>	Wrist/Hand Pain	<input type="radio"/>	<input type="radio"/>	Blood Clots			<b><u>Ear/Nose/Throat</u></b>
<input type="radio"/>	<input type="radio"/>	Hip/Upper Leg Pain	<input type="radio"/>	<input type="radio"/>	Vascular Disease	<input type="radio"/>	<input type="radio"/>	Allergies/Asthma
<input type="radio"/>	<input type="radio"/>	Knee/Lower Leg Pain			<b><u>Metabolic</u></b>	<input type="radio"/>	<input type="radio"/>	Chronic Sinusitis
<input type="radio"/>	<input type="radio"/>	Ankle/Foot Pain	<input type="radio"/>	<input type="radio"/>	Abnormal Weight Gain/Loss			<b><u>Systemic Conditions</u></b>
<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	Low Bone Density	<input type="radio"/>	<input type="radio"/>	Cancer/Tumors
<input type="radio"/>	<input type="radio"/>	Joint Swelling/Stiffness	<input type="radio"/>	<input type="radio"/>	Excessive Thirst	<input type="radio"/>	<input type="radio"/>	Chronic Fatigue
<input type="radio"/>	<input type="radio"/>	Joint Dislocation	<input type="radio"/>	<input type="radio"/>	Hormone Therapy	<input type="radio"/>	<input type="radio"/>	Systemic Lupus
<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	Thyroid Problems	<input type="radio"/>	<input type="radio"/>	Spinal Infection
<input type="radio"/>	<input type="radio"/>	Jaw Pain			<b><u>Gastrointestinal</u></b>	<input type="radio"/>	<input type="radio"/>	HIV/AIDS
		<b><u>Neurological</u></b>	<input type="radio"/>	<input type="radio"/>	Abdominal Pain	<input type="radio"/>	<input type="radio"/>	Hepatitis
<input type="radio"/>	<input type="radio"/>	Concussion	<input type="radio"/>	<input type="radio"/>	Liver/Gallbladder Disorder	<input type="radio"/>	<input type="radio"/>	Anemia
<input type="radio"/>	<input type="radio"/>	Memory Loss	<input type="radio"/>	<input type="radio"/>	Ulcer			<b><u>Psychological</u></b>
<input type="radio"/>	<input type="radio"/>	Epilepsy			<b><u>Dermatological</u></b>	<input type="radio"/>	<input type="radio"/>	Depression
<input type="radio"/>	<input type="radio"/>	Excessive Weakness	<input type="radio"/>	<input type="radio"/>	Dermatitis/Eczema	<input type="radio"/>	<input type="radio"/>	Anxiety
<input type="radio"/>	<input type="radio"/>	Loss of Sensation/Bowel/Bladder Function	<input type="radio"/>	<input type="radio"/>	Psoriasis	<input type="radio"/>	<input type="radio"/>	Alcohol/Drug Abuse
<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	Acne	<input type="radio"/>	<input type="radio"/>	Mood Swings

**Spring Valley Clinic**  
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## Consent to Treat

I, \_\_\_\_\_, voluntarily consent to be treated with Acupuncture administered by Amanda Bryant Melo.

I understand that the Acupuncture will be performed by the insertion of sterile, disposable needles through the skin, or by application of heat, or by some combination of the foregoing, at certain points on my body; and that such treatment is intended to improve body function and relieve pain.

I have been informed that although rare, side effects may result from my Acupuncture treatment. These could include some minor pain or discomfort, localized bruising, fainting, nausea and the temporary aggravation of pre-existing conditions.

I accept that No Guarantee is made concerning the results of my Acupuncture treatment, and I have been informed that I may stop at any time.

I consent also to the submission of any data relating to my Acupuncture treatments to any health insurer with whom I have coverage, and understand that this does not otherwise waive my right to confidentiality of my records.

All questions I have asked have been fully answered.

Signature of Patient ( or Guardian)\_\_\_\_\_

Dated\_\_\_\_\_

DOB\_\_\_\_\_

## EVALUATION REQUEST

I have been treated by a physician or a dentist for the condition being treated within twelve months prior to having acupuncture performed.                      Yes                      No

I received a referral from my chiropractor within the last thirty days for acupuncture.    Yes                      No

I recognize that I should be evaluated by a physician for the condition being treated by the acupuncturist. In being referred by my chiropractor, if after 60 days or 20 treatments, whichever comes first, if no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. This does not apply to the following conditions: chronic pain, alcoholism and substance abuse, smoking cessation or weight loss.

Signature of Patient ( or Guardian)\_\_\_\_\_

Dated\_\_\_\_\_

DOB\_\_\_\_\_

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## Patient Consent for use and Disclosure of Protected Health Information

Medical groups must provide patients with a notice describing how protected health information may be used and disclosed. This information includes patient's rights and medical group's duties.

I hereby give consent for **Spring Valley Clinic** to us and disclose protected health information (PHT) about me to carry out treatment, payment and health care operations (TPO). (The *Notice of Privacy Practices* provided by **Spring Valley Clinic** describes such uses and disclosures more completely.)

I have the right to review the *Notice of Privacy Practices* prior to signing this consent. **Spring Valley Clinic** reserves the right to revise the *Notice of Privacy Practices* at any time. A revised *Notice of Privacy Practices* may be obtained behind the front desk at our office at 5323 Spring Valley Rd., Ste 100, Dallas, Texas 75254.

With this consent, **Spring Valley Clinic** may call my home or other alternative location and leave a message on voice mail or by person, mail correspondence through USPS or similar means or electronic mail (email) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including diagnostic testing results, among others.

\_\_\_\_\_ I acknowledge that I have been informed that I can request a copy of the Notice of Privacy Practices from **Spring Valley Clinic** and consent to allow them to use and disclose my PHT to carry out TPO.

\_\_\_\_\_ I have received a copy of Notice of Privacy Practices from **Spring Valley Clinic**.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Spring Valley Clinic** may decline to provide treatment to me.

Signed By: \_\_\_\_\_  
(Signature of patient or Legal Guardian) (Date) (Relationship to patient if other than self)

\_\_\_\_\_  
(Print Patient Name) (Print name of Legal Guardian if applicable)